PH Financing Committee Meeting Notes
October 25, 2002

Present: Lois Speelman, Tim McDonald, Joan Brewster, Nancy Cherry, Larry Jecha, Maggie Moran, Vicki Kirkpatrick, John Manning, Rick Mockler, Alice Porter, Steve Russman, Carol Villers, Marty Wine, Ursula Roosen-Runge

Overview of Agenda/New Challenges

State is facing a $2-$3 billion shortfall in general fund and $500 million in the Health Services Account. MVET backfill continues to be an issue for the upcoming legislative session. City and county associations are working together on the public health legislative agenda and dedicated funding stream. Problems with the economy could lag into 2004; legislative session expected to be long and difficult.

Sea-King has a workplan to be much more proactive and visible with legislators. In Seattle, a summit was held with City Councilmembers and state legislators from Seattle to discuss local and state perspectives on financing public health and generate creative solutions. The summit and early discussions with legislators highlighted the need to clearly articulate what would be done with any restoration or increases to public health funding, and to identify areas where efficiencies can be gained. Committee discussed that given city and county cuts, public health is still not adequately funded to provide services. Another outcome of the summit was that a subgroup was convened to advocate for public health funding. The group has developed messages that identify current problems with financing public health, acknowledge that public health problems are borderless, and the messages begin to discuss funding approaches.

In other areas, one district's budget assumes that MVET backfill will be provided; another reports a county laying of one-third of its health staff. Without stabilized funding, this problem will worsen. Another area reports that the budget is stable – they will have delivered the same consistent messages to multiple boards of health about stable funding, and some of these board members are unwilling to cut public health. The Committee also briefly discussed DSHS cuts; at one time the services were described as "safety net," but cuts are now at described as a level that will only "maintain sustenance" for those who depend on DSHS services.

Public health's role is shifting – governments have been unprepared for the public health role in responding to the public's safety. Need to use information from the cost model to try to describe the problem. Earlier in the fall, for the Washington State Public Health Association conference, a resolution was passed encouraging support for additional funding and named a dollar amount of $25 million; in reality this number is much higher ($300 million or more). While not all this amount is requested from state or federal sources, public health practitioners have been unprepared and shy about saying that "public health is public safety." If the public expects public health departments and districts to be first responder, these issues need to be elevated.

Cost Model Update

Reviewed the comments from WSALPHO forums/groups. Overall the effort is viewed positively as a useful communications tool and a good tie to the development of standards. Thanks to

the members of the Committee for their help presenting and forum participants for their input. Majority of WSALPHO comments focused on 1) whether minimums for small counties should be incorporated into the model, since many LHJs said that below a certain staffing level, some functions weren't worth continuing; and 2) whether some program best practices exist for staffing that could be used to create cost drivers. This is probably true on a program-by-program basis; Marty will continue to research.

The Committee discussed and agreed that it's important to call the beginning point from which we'll develop scenarios something other than "baseline." "Theoretical baseline" or "starting point" were suggested. The starting point (where we are now) is not the message, and individual LHJ findings are not the message; the message is really "we can achieve the standards for $____." Committee members reiterated that no staffing minimums are desired for the starting point, and that one scenario might be to develop minimums by standard. The intent of the model is not to communicate anything according to individual jurisdictions, but for the calculations to reflect the state as a whole.

For the November meeting, Marty will remove cost drivers that assume minimum staffing, work with DOH to complete the state "side" of the model, receive final feedback from environmental health directors and public health nursing directors with any other ideas for drivers, and provide a report to the Committee about the "starting point." For the purposes of communications during the Legislative session, some Committee members will need the "starting point" totals for the environmental health, communicable disease, and understanding health issues standards.

Economies of Scale: Elements of the Model Affected by Size and Scope

The group reviewed materials sent in advance about economies of scale, its definition, how they are achieved and how diseconomies of scale occur. In preparation for building scenarios beginning in January, the Committee was polled about what consultant assumptions, givens, constants, areas of greatest interest, and taboos were.

Taboo
- Overt governance reorganization

Assumptions and Constants:
- There are economies and diseconomies of scale
- Services will be provided at a community/local level
- Scenarios will look both state-down and locals-up
- Politics will never be eliminated
- Use a program/service model (not fiscal)
- Efficiency does not necessarily mean better services
- Tell the truth, but number will set a context only

Most interested in learning about:
- Look at economies in groups of services (or standards) – is this a viable approach
- Do we have a sense of an optimal level of oversight and accountability? How many layers or levels is efficient?

- In the future: test the assumption that largest budgets are best able to meet standards. What other variables are predictors or lead to success in meeting the standards (e.g. is it size, or per capita investment?) (Multivariate analysis of other factors)
- Existing partnerships
- What other models can be used to model/structure "local ownership?"

Comments/ideas from the Committee about economies of scale:

- The principle of diseconomies resonated with the group – DSHS and King County were given as examples.
- The idea of fixed costs relates back to the "minimum staffing" issue. There is an amount of time for staff to meet, do administrative tasks (timesheets etc.); sometimes it doesn't make sense to hire someone part-time with fixed costs such as health insurance, recruitment/retention.
- Rural areas don't have staff that are dedicated to a single function – they do multiple programs and combine the work. This means that they need to track and network in multiple programs. (This is really an economy of scope.)
- LHJs tend to hire nursing staff at 80% time or have specialized staff (e.g. NP) who serve large area to gain economies (NE Tri County)
- Also an issue: with low volumes, can't charge enough to capture revenues to cover the costs.
- State tends to use population centers as a starting point and distributes money that way when the concept of "regional" is discussed. Have to provide a consistent level of service across the state, and then discuss economies of scale. Don't just focus on largest population because you know you'll be reaching the most number of people.
- There is substantial value to a local connection.
- Any service begins with the assumption that services must be provided locally. (Not regionally)
- In areas such as Benton-Franklin, there are diseconomies in having to have 3 offices in the Tri-Cities. Similarly, geography can affect both diseconomy and economy – e.g. San Juan that can do inspections efficiently – but needs to have an office on each of the main islands.

PHIP Recommendations

In June the Committee agreed that PHIP recommendations would be based on the work that is ready, and what the Steering and Financing Committee are positioned to do, or are informed enough to do, by the month of November.

1) The Committee previously agreed to move forward with recommendations for cost modeling in June:

- Accept cost model as a tool for conveying the cost to provide public health services statewide
- Develop and identify sound cost drivers for state public health activities
- Test and refine the model with the help of WSALPHO
- Continue cost modeling efforts toward a) identifying economies of scale and b) applying those to regional approaches.
- The Committee reasoned that they might be able to say "we stand behind the following ideas – use financing principles plus the cost model to guide the financing of the

system; where different regions, different structures, or proportions of investments can occur, we want to move forward with them."

2) Joan, Tim, Lois and Marty prepared an early draft of the PHIP Finance chapter, based on an earlier PHIP Steering Committee meeting. The Committee read and responded to this draft paragraph by paragraph. The group offered editorial suggestions for the majority of the document. Joan, Tim, Lois and Alice will incorporate these comments for a new draft (probably to be reviewed by e-mail during November as the PHIP chapters progress). The Committee was not ready to make a recommendation about funding the system differently and discussed either dropping or re-wording that section (recommendation #3 on page 3 of that handout). Committee will need to discuss this and have general recommendations finalized at the November meeting.

Next meeting: November 25, 2002, SeaTac (exact location to be determined). Lois and Steve will try to convene the subgroup (Vicki, Rick, Larry, Lois and DOH representatives) between now and November to draft a work scope for a restructured advisory committee that focuses on funding allocation in the Prevention/Promotion category.